Performance Audit
Ryan White Funding Equity

March 1999

City Auditor's Office

City of Kansas City, Missouri

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KANSAS CITY
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March 15, 1999

Honorable Mayor and Members of the City Council:

This performance audit of the Ryan White Title I program was conducted by the city auditor at the direction of the Finance and Administration Committee. Mayor Emanuel Cleaver II asked the committee to direct us to do the audit because of complaints he had received regarding minority participation in and funding from the Ryan White program. The performance audit focuses on equity in the allocation of funds for the provision of services to HIV/AIDS patients in the Kansas City metropolitan area.

The Ryan White Title I program provides federal funds to eligible metropolitan areas affected by the HIV/AIDS epidemic. The mayor, who is the official recipient of the Ryan White Title I grant, appoints a Planning Council responsible for setting spending priorities based on its determination of the needs of area HIV/AIDS patients. The Kansas City Health Department distributes funds among area service providers.

We did not identify any areas in the operation of the program in which it appeared that clients or service providers were being treated unfairly. We did find, however, several areas in which a lack of understanding could contribute to mistrust and dissatisfaction. We found, for example, that although the composition of the Ryan White Planning Council exceeds federal guidelines concerning the percentage of members with AIDS, many of those members feel they have received inadequate training in their role. Members of the council reported that they are uncomfortable with their level of understanding of Planning Council procedures, and some reported that they do not understand the financial information provided by the Health Department. The lack of understanding on the part of Planning Council members could lead to misunderstandings regarding the role of the council and suspicion regarding its financial activities. In order for all Planning Council members to have the opportunity to participate fully in the council's activities, we recommend increased orientation and training, particularly in the use of financial reports.

We also found that, although there was no evidence of unfair treatment of proposals submitted by service providers seeking Ryan White contracts, there are procedural limitations that may create a perception of unfairness. The Division of Purchases and Supplies' procurement procedures comply with the minimum requirements of the federal legislation. We found, however, that the procedures do not provide adequate documentation that all proposals receive equal consideration. Proposals are evaluated by Health Department selection panels, which score bids for Ryan White services and award contracts to bidders with the highest total scores. However, the panels' deliberations are not recorded. As a result, it is difficult to verify how the panels arrived at their award decisions. The absence of documentation that clearly supports the integrity of the contract award process could contribute to the mistrust communicated to the mayor.

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We also found that the procedures followed by the Division of Purchases and Supplies do not include several "best practices" identified in literature as common for procurement of services of this type. Incorporating these practices will strengthen the Ryan White procurement process and could further reduce feelings of mistrust towards the city on the part of Ryan White service providers.

Finally, some Planning Council members suggested that some HIV/AIDS patients believe they are unfairly prevented from obtaining Ryan White services. Some of these complaints may be the result of the lack of understanding of who qualifies for services, or the lack of written appeal procedures providing recourse to clients terminated from services. The complaints could, however, be the result of perceived barriers to service for minority HIV/AIDS patients. Members of the Planning Council also suggested that some minority HIV/AIDS patients might be uncomfortable with current service providers. HIV/AIDS has recently affected minority communities nationally at a faster rate than Caucasians. Locally, the percentage of newly diagnosed HIV/AIDS patients that are minorities exceeds their percentage of the area population. The studies done by the federal government have determined that minorities encounter obstacles that prevent them from receiving equal access to Ryan White care. Some Kansas City Planning Council members expressed similar sentiments.

Due to confidentiality of HIV/AIDS patients and other factors, we were unable to determine whether barriers to care for minorities exist in Kansas City and, if so, how pervasive such barriers are. Should these barriers exist, they would be another source of the sense of mistrust surrounding the program. We suggest, therefore, that the Planning Council consider undertaking a comprehensive study of the provision of services to HIV/AIDS patients in the Kansas City area, including barriers to that care and evaluations of the services currently provided.

A copy of the draft report was delivered to the Health Director on February 12, 1999 for review and comment. His written response is included as an appendix. We appreciate the cooperation extended to us during the audit by Health Department staff. The audit team for this project was Anatoli Douditski, Joyce Patton, and Gary White.

Mark Funkhouser
City Auditor

Ryan White Funding Equity

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Introduction

Report Objectives

This performance audit of funding equity in Kansas City's Ryan White Title I Program was conducted pursuant to Article II, Section 13 of the Charter of Kansas City, Missouri, which establishes the Office of the City Auditor and outlines the city auditor's primary duties.

A performance audit is an objective, systematic examination of evidence to independently assess the performance of a government organization, program, activity, or function in order to provide information to improve public accountability and facilitate decision-making.[1] The audit began with a request by Mayor Emanuel Cleaver II to investigate complaints regarding minority participation in and funding from the Ryan White program. The audit was designed to answer the following questions:

- Does the current Ryan White Planning Council membership comply with the requirements of the funding legislation and adequately represent the composition of area residents affected by HIV/AIDS?

- Does distrust exist between minority groups, the Health Department, and the Ryan White Planning Council regarding HIV/AIDS funding issues? If so, how can this distrust be mitigated?

- How do the Planning Council and the Health Department decide which proposals submitted by area agencies to provide HIV/AIDS-related services will be funded from Ryan White monies?

a. Do all proposals receive equal consideration, regardless of their source?
b. Do contracting activities comply with the requirements of the funding legislation?

- Have the Planning Council and the Health Department identified barriers to care that affect minority populations, and have they taken steps to address those barriers?

[1] Comptroller General of the United States, *Government Auditing Standards* (Washington, D.C.: U.S. Government Printing Office, 1994), p. 14.

Scope and Methodology

The audit was performed in accordance with generally accepted government auditing standards with the exception of an external quality control review within the last three years.[2] Methods included:

- Reviewing the U.S. Department of Health and Human Services Ryan White CARE manual, training guide, and other relevant documents.
- Reviewing National Association of State Purchasing Officials publications as well as other relevant sources to identify "best practices" in procurement.
- Interviewing city staff, staff from HIV/AIDS service organizations, and members of the Ryan White Planning Council.
- Conducting a survey of Ryan White service providers.
- Conducting a survey of the Ryan White Planning Council members.

No information was omitted from this report because it was deemed privileged or confidential.

Background

In 1990, Congress adopted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The act represents the largest dollar investment made by the federal government specifically for the provision of services for people with HIV disease. Ryan White Title I funds are funneled to metropolitan areas hardest hit by the HIV/AIDS epidemic. To be eligible, metropolitan areas must have more than 2,000 cumulative AIDS cases in the most recent five-year period and a population of at least 500,000 (unless already designated eligible as of FY 1996). The eligible metropolitan area for Kansas City includes seven counties in Missouri and four counties in Kansas.[3]

Funds are awarded according to a formula based on the estimated number of living AIDS cases in the area in the year prior to an award. To avoid undermining existing services, the formula funding received cannot decrease to less than a certain percentage of the fiscal year 1995

[2] The last review was performed in April 1995. A peer review is planned for the current year.

[3] Cass, Clay, Clinton, Jackson, Lafayette, Platte, and Ray counties in Missouri, and Johnson, Leavenworth, Miami, and Wyandotte counties in Kansas.

award. Once the formula funding is determined, the remaining Title I funds are distributed as supplemental awards. Supplemental funds are based upon competitive applications from eligible areas that demonstrate an additional need for financial assistance.

Funding

The Kansas City area became eligible in March 31, 1993 to receive Ryan White Title I funding for fiscal year 1994. In fiscal year 1999, the Kansas City area received approximately $2.9 million in Ryan White Title I funds. (See Exhibit 1.)

Exhibit 1. Cumulative AIDS Cases and Ryan White Title I Funding for the Kansas City Metropolitan Area

Fiscal Year	Cumulative AIDS Cases	Formula Award	Supplemental Award	Total Ryan White Title I
1994	2,031	$1,251,712	$1,403,852	$2,655,564
1995	2,334	1,145,290	1,580,905	2,726,195
1996	2,636	1,345,926	1,168,365	2,514,291
1997	2,954	1,469,692	1,414,845	2,884,537
1998	3,157	1,452,310	1,170,099	2,622,409
1999	3,363	1,476,788	1,459,918	2,936,706[4]

Source: Kansas City Health Department.

Program Operation

Under the law, the mayor is the official recipient of Title I CARE Act funds. The chief elected official is responsible for nominating a Ryan White Planning Council charged with establishing spending priorities, developing a plan for meeting those priorities, and performing a limited evaluation function. The Planning Council may not designate, recommend, or otherwise be involved in the selection of particular entities as recipients of any amounts provided in the grant.

Funding may be awarded to public or nonprofit entities. Private for-profit entities are eligible to receive funding if they are the only available providers of HIV/AIDS care in the area. Services eligible for funding include outpatient and ambulatory health and support services including case management, substance abuse and mental health treatment, and comprehensive treatment services for individuals and families with HIV disease.

[4] Does not include Congressional Black Caucus funding of $16,204 added to the legislated appropriation in the 1999 award specifically for the provision of services directed toward minorities.

Selecting Service Providers

Grant funds must be spent throughout the 11-county area. The Health Department and the Finance Department's Purchases and Supplies Division share responsibility for selecting service providers serving HIV/AIDS patients for all 11 counties in the Kansas City area under Ryan White.

Grant funds are awarded to area agencies according to the priorities and dollar amounts established by the Planning Council. Exhibit 2 shows Planning Council allocations and the number of Health Department contracts with Ryan White service providers in 1998.

Exhibit 2. Ryan White Title I Planning Council Allocations and Health Department Contracts in Fiscal Year 1998

Service Priority	Number of Contracts	Title I Allocation
Medications	4	$651,316
Case Management	9	545,849
Food	3	240,500
Primary Care	1	234,267
Housing	1	210,000
Transportation	1	101,000
Dental	2	86,740
Home Health Care	5	83,500
Mental Health/Counseling	1	77,495
Emergency Assistance	1	77,000
Ryan White Marketing	1	17,896
Needs Assessment	1	16,000
Permanency Planning	1	15,000

Source: Kansas City Health Department.

Client Services

Case managers serve as the primary gatekeepers for client access to services. Case managers verify HIV positive status and income, develop a service plan with their clients, and assess the clients' need for Ryan White services. Ryan White is not an entitlement program but a payer of last resort. In order to receive a Ryan White-funded service, HIV-positive clients must receive authorization from their assigned case managers. The Kansas City Health Department's case management supervisor assigns clients to case managers based on the client's home address and the location of the client's primary physician. Clients can choose where to receive their Ryan White-funded services if more than one provider offers the same service.

Findings and Recommendations

Summary

Mayor Emanuel Cleaver II asked us to look into the Ryan White program because of complaints he had received regarding programs funded through the grant and regarding minority participation in those programs.

We did not identify any areas in the operation of the program in which it appeared that clients or service providers were being treated unfairly. We did find, however, several areas in which a lack of understanding could contribute to mistrust and dissatisfaction. We found, for example, that although the composition of the Ryan White Planning Council exceeds federal guidelines concerning the percentage of members with AIDS, many of those members feel they have received inadequate training in their role. Members of the council reported that they are uncomfortable with their level of understanding of Planning Council procedures, and some reported that they do not understand the financial information provided by the Health Department. The mistrust reported to the mayor could be the result of a lack of understanding about the role of the council and its activities.

We also found that, although there was no evidence of unfair treatment of proposals submitted by service providers seeking Ryan White contracts, procedural limitations may contribute to a perception of unfairness. The procurement procedures comply with the minimum requirements of the federal legislation. We found, however, that the procedures do not provide adequate documentation that all proposals receive equal consideration. Selection panels assigned by the Health Department, for example, scored bids for Ryan White services and awarded contracts to bidders with the highest total scores. The selection panels' deliberations were not recorded, however, and it is difficult to determine how they arrived at their decisions. The lack of openness and accountability in the procurement process raises questions about the integrity of that process, and could contribute to the mistrust expressed to the mayor. In addition, procedures followed by the Health Department and the Division of Purchases and Supplies do not include several "best practices" identified in literature as common for procurement of services of this type.

Finally, studies done by the federal government have determined that minorities may encounter obstacles that prevent them from receiving equal access to Ryan White care. Due to confidentiality of HIV/AIDS

patients and other factors, we were unable to determine whether barriers to care for minorities exist in Kansas City and, if so, how pervasive such barriers are. Should these barriers exist, they would be another source of the sense of mistrust surrounding the program. We suggest, therefore, that the Planning Council consider undertaking a comprehensive study of barriers to care in the Kansas City area.

Mistrust Could Result from a Lack of Understanding

The Ryan White Planning Council includes people from diverse backgrounds. Health care officials, community representatives, representatives of non-profit organizations, and public and private health care providers and people with HIV/AIDS are expected to work productively as a council. Together, the members of the Planning Council are expected to prioritize services and allocate funding to provide necessary assistance to people with HIV/AIDS in the Kansas City area.

Some Planning Council members indicated that they suspect favoritism and bias on the part of government bureaucrats who are used to working in a political environment. One Planning Council member reported that church leaders and community activists have the skills and expertise to assist HIV/AIDS patients, particularly minorities, but view the formal rules that the government introduces to the process as an artificial obstacle. Finally, other members of the Planning Council indicate that HIV/AIDS community representatives may experience difficulty in working on an equal basis with other Planning Council members.

These divergent perspectives create a challenging atmosphere of conflicting views that may lead to mistrust between HIV/AIDS patients, minority groups, the Health Department, and the Ryan White Planning Council.

Planning Council Membership Complies with Federal Requirements

The membership of the Kansas City Planning Council reflects the demographics of the disease in the eligible metropolitan area as well as the population of the metropolitan area at large. Federal legislation contains specific requirements regarding the Planning Council composition. Under the law, the Planning Council membership should include representatives of the following groups:

- Health care providers, including federally qualified health centers;
- Community-based organizations serving affected populations;
- Social service providers;
- Mental health and substance abuse providers;
- Local public health agencies;
- Hospital planning agencies or health care planning agencies;
- Affected communities, including people living with HIV or AIDS and historically under-served groups;
- Non-elected community leaders;
- State government including the State Medicaid agency and the Title II program;
- Title III grantees;
- Title VI program, or organizations with a history of serving children, youth, and families with HIV; and
- Grantees under other federal HIV programs.[5]

Membership of those living with HIV/AIDS exceeds federal requirements. The Ryan White CARE Act also requires the full and effective involvement of people living with HIV/AIDS at all levels of planning, implementation, and evaluation within the Planning Council. The Planning Council must also reflect the demographics of the epidemic in the eligible metropolitan area with particular consideration given to disproportionately affected and historically under-served groups. At least 25 percent of the Planning Council members must be people living with HIV/AIDS.

As of November 30, 1998, 36 of the Planning Council's 43 positions were filled. People living with HIV/AIDS made up about 39 percent of the membership. The composition of the Planning Council complies with federal requirements and reflects the demographics of the AIDS epidemic in the Kansas City metro area. Exhibit 3 provides demographic information about the HIV/AIDS-infected population and the Planning Council.

[5] *Training Guide: A Resource for Orienting & Training Planning Council and Consortium Members,* (Washington D.C.: prepared by The Center for Nonprofit Development and Pluralism, for the Division of HIV Services Bureau of Health Resources Development, March 4, 1997), p. 3-86.

Exhibit 3. Infected Population and Ryan White Planning Council Composition Comparison

Race/Ethnicity And Gender	Total HIV Cases As of 03/31/98	Ryan White Planning Council
Caucasian	63%	63%
African-American	31%	32%
Hispanic	5%	5%
Asian/Pacific Islander	Less than 1%	0%
Native American/Alaskan	1%	0%
Male	89%	53%
Female	11%	47%

Source: Fiscal Year 1999 Grant Application.

Planning Council Members Indicate a Need for Training

Some Planning Council members expressed discomfort with their level of understanding of the council's role. Others indicated that they do not understand the financial information provided by the Health Department. Some of the mistrust expressed about the Ryan White program may be the result of a lack of understanding about the council, its activities, and its financial activities.

Survey results. We designed a questionnaire to gather information on the perceptions of those participating in the Ryan White program, particularly HIV/AIDS clients. However, because HIV/AIDS patient confidentiality is a very sensitive issue and because of the difficulty involved in surveying people throughout the 11-county area, we decided not to administer the survey to Ryan White patients.

Instead, we limited the scope of the survey to members of the Planning Council. We assumed that since the Planning Council's composition reflects the Ryan White community in Kansas City, the views of the council members would be helpful in identifying problem areas. The survey instrument and the answers of the Planning Council members are included in Appendix A.

Planning Council members expressed uncertainty about their role. Although not all members of the Planning Council returned their surveys, those that did provide some indication of the problem areas. Responses to our survey showed that 10 out of 19 respondents feel they have not been adequately trained to effectively perform as Planning Council members. Several members said that they are uncomfortable with their level of understanding of Planning Council procedures.

Nine out of nineteen respondents indicated that they do not understand the financial information provided by the Health Department. In

addition, 8 out of 19 respondents said they are uncomfortable with the amount of conflict among Planning Council members.

The lack of understanding on the part of Planning Council members could lead to misunderstandings regarding the role of the council and suspicion regarding its financial activities, and could be contributing to the conflicts among Planning Council members. In order to ensure that all Planning Council members have the opportunity to participate fully in making informed decisions, the Planning Council should prepare an orientation and training plan for its members, covering subjects such as the role of the council, procedures, and financial reports.

Procurement Practices Could Appear Unfair

Individuals and service providers have alleged that minority service providers do not receive Ryan White contracts partly because Health Department officials are biased against agencies bidding for Ryan White services for the first time. Although we found no evidence of unfair treatment of proposals submitted by area service providers seeking Ryan White contracts, we did identify some procedural limitations that may create a perception of unfairness. Specifically, a lack of accountability and documentation of decision-making could contribute to the mistrust expressed to the mayor regarding selection of service providers.

In awarding Ryan White contracts to area service agencies, the Health Department and Purchasing Division have followed the requirements of the federal funding legislation. By expanding the process to include additional elements recommended in procurement literature, however, the city could increase the openness of the process and reduce the appearance of unfairness.

Procurement Procedures Comply with Minimum Federal Requirements

The Health Department's procurement procedures for Ryan White contracts comply with the requirements of the federal legislation. Under the law, local government Ryan White Title I grantees may use their own procurement procedures as long as those procedures comply with applicable laws and regulations.[6]

The Finance Department's Division of Purchases and Supplies handles procurement for Ryan White services. After receiving bid specifications from the Health Department, the Purchases and Supplies Division mails

[6] OMB Circular A-102 or 45 CFR Part 92.

requests for proposals (RFPs) to organizations identified by the Health Department as capable of providing Ryan White services. In addition, advertisements for RFPs are placed in local media and are mailed to other potential service providers upon request. Included in the RFP are general instructions for eligibility to bid, proposal guidelines, evaluation factors, and a narrative worksheet for answering basic questions about the service provider and its ability to provide requested services.

The contracting officer assigned to handle the program's RFPs conducts pre-bid conferences with potential service providers. Health Department administrative personnel attend the conferences to answer questions. Within 30 days of the pre-bid conference, proposals are due to the city for review.

The Health Department assigns a separate selection panel to evaluate RFPs for each service put out for bid. Selection members include Health Department officials, the purchasing officer, and other experts depending on the nature of the service put out for bid. Contracts are awarded to bidders with the highest total score as determined by the panels. Successful bidders are notified of their contract awards.

Contract award procedures could contribute to mistrust. Individuals and service providers have alleged that minority service providers do not receive Ryan White contracts partly because Health Department officials are biased against agencies bidding for Ryan White services for the first time. Three agencies that provide services to minority communities of the Kansas City eligible metropolitan area lost their bid for Ryan White case management. The complaints state that as a result, minority Ryan White clients have suffered because minority HIV/AIDS clients allegedly prefer to receive services from minority providers. Our survey of Ryan White service providers indicated that 4 out of 21 respondents thought that their bids were evaluated unfairly. (See Appendix B.)

According to the Health Department staff, two of the agencies not receiving case management contracts are minority community based organizations (CBOs) as defined by the Health Resources and Services Administration. The two minority CBOs, (Native American Health/AIDS Coalition, and Guadalupe) were awarded education/prevention contracts through the procurement procedures but not Ryan White case management contracts. Three other minority CBOs were awarded Ryan White case management contracts. All case management agencies serve minorities.

Although we found no evidence that bids were evaluated unfairly, we did identify aspects of the selection procedures that could contribute to a perception of unfairness.

Lack of accountability over contract award decisions. The Health Department selection panels score bids for Ryan White services and award contracts to bidders with high total scores. However, the panels' deliberations are not recorded. As a result, it is difficult to determine how the committees arrived at their award decisions. The absence of documentation could lead unsuccessful applicants to question the integrity of the process.

In awarding case management contracts, for example, the scoring panel rejected all bidders whose applications fell below 51 percent of the total possible score. There are no records indicating when and why the score was set at this particular level. Setting the minimum score at 51 percent resulted in rejections for the three agencies claiming to provide services to specific minority populations. Procurement procedures that do not seem open and above-board damage the credibility and integrity of the process and could contribute to accusations of unfairness and discrimination.

Unsuccessful bidders not notified. Although service providers whose bids are successful are notified of their contract awards, the Purchasing Division does not inform the other service providers that their bids were unsuccessful. Notifying all Ryan White bidders of the procurement results could improve the credibility of the process.

Grievance procedures are adequate. The Health Department and Planning Council's grievance procedures appear to provide proper and adequate recourse to service providers who feel their bids were evaluated unfairly. In addition to the use of Ryan White grievance procedures, bidders can file complaints with the commissioner of Purchases and Supplies. None of the Ryan White service providers has ever filed any grievances or complaints regarding the fairness and equity in the Health Department's procurement process.

Procurement Procedures Should Be Strengthened

The federal government has developed extensive rules to assure equal access to Ryan White funding and equal treatment of proposals. The city's procurement process, for the most part, complies with these rules. Yet there remains a significant level of distrust between service providers, the Health Department, and the Purchases and Supplies Division.

We identified some "best practices" in procurement, which do not constitute official requirements but which, if followed, could improve the

openness and credibility of the procurement process.[7] Our audit work indicated that some "best practices" are already part of the vendor selection process. For example, the Health Department and the purchasing officer advertise Requests for Proposals not only in the mainstream media but also in alternative gay and lesbian newspapers. However, incorporating more of the "best practices" will strengthen the Ryan White procurement process and could reduce feelings of mistrust towards the city on the part of Ryan White service providers.

The practices that should be incorporated are as follows:

[7] Sources used included: Donald F. Harney, *Service Contracting. A Local Government Guide,* (Washington D.C.: International City/County Management Association, 1992); David P. Gragan, *State and Local Government Purchasing Principles & Practices,* (Lexington, KY: National Association of State Purchasing Officials, 1997); and U.S. Department of Health and Human Services, *Ryan White C.A.R.E. Act Title I Manual.*

"Best Practices" in Procurement

- Competitive negotiation should be used for medical and social services contracts. The procedure allows an award to the contractor with the best combination of price, experience, and quality of service delivery. Also, if the procurement official and the evaluation committee determine after an initial evaluation of proposals that negotiations with bidders are advantageous, all bidders whose proposals are identified as acceptable must be given equal opportunity to negotiate and revise their proposals.

- Scoring panels should have an odd number of members, with the procurement official deciding who may sit on the committee. The recommendation of the committee is purely advisory and the procurement official should make the final decision.

- Members of the evaluation committee should be required to sign a conflict of interest/confidentiality statement before receiving copies of proposals to ensure the integrity of the procurement process.

- To ensure that the evaluation panel members understand their roles and responsibilities, they need one or more training sessions.

- The employment of an evaluation committee should be structured, formal, and a matter of record. Committee deliberations should be recorded. Score sheets and minutes of evaluation committee meetings should become a part of the procurement file. All procurement records should be available for public inspection upon request. The documentation of the procurement decision should be sufficient to allow competing bidders, the press, and the auditors to see the basis for the award decisions.

- Purchasing officers should participate on the evaluation panel only as ex-officio members. Their non-voting status is necessary because their possible future roles as mediators of contract disputes, enforcers of contract provisions, and initiators of litigation against a contractor may require them to render impartial decisions.

- The use of Title I CARE Act funds for delivery of particular services by the Health Department should be based on decisions by the evaluation committee and/or an objective review process. This procurement should be subject to a public process if there are other entities in the community that could provide the priority service.

The process should be more open. Although we did not find any evidence of bids being evaluated unfairly, there is a need for the integrity of the procurement process to be strengthened so that it will better withstand public scrutiny. When decisions are not made in an open, above-board manner, there is the risk that decisions will be misinterpreted. By correcting these shortcomings, the Purchases and Supplies Division will be able to improve the transparency and credibility of its RFP procedure, thus eliminating the perception of unfairness expressed by some service providers.

Mistrust Could Be the Result of Perceived Barriers to Care

Some Planning Council members alleged that minority HIV/AIDS clients might feel uncomfortable receiving services from current service providers. In some cases this discomfort may be strong enough to create barriers to access to Ryan White services. These barriers could lead to mistrust on the part of clients who feel that decisions about their care are unfair or are not in their best interests.

Some of the complaints involve patients having been terminated from services due to violating program rules. We found that the Health Department has not developed written termination or appeal procedures. The absence of written procedures could lead to an impression that termination is arbitrary.

In addition, studies have shown that cultural and other barriers may prevent minority HIV/AIDS patients from obtaining services. These barriers, if they exist in Kansas City, could contribute to mistrust and a sense of unfairness regarding the Ryan White program. Concerns regarding confidentiality issues precluded us from surveying HIV/AIDS patients to determine whether they have experienced difficulty in obtaining services in Kansas City. We suggest that the Planning Council undertake a comprehensive study of various HIV/AIDS issues, including an evaluation of the services currently being provided.

No Written Termination and Appeal Procedures

Although written information states that clients can appeal suspension or termination decisions made by program personnel, there is no written appeal process, and the termination process is not formally described. As a result, patients are faced with a threat that they can be terminated from certain services for violating stated rules, but may not know how the termination will work or how it can be appealed.

Clients can be suspended or terminated from Ryan White services for violations of the rules described in the "Ryan White Client Rights and Responsibilities" contract. Clients are made aware of the rules when they first enter the Ryan White service system. Clients who feel they have been suspended or removed from services unjustly may file a grievance and/or ask for a review.

The Health Department has not, however, developed written termination and appeal procedures. Without written procedures, decisions could appear arbitrary. The threat of termination, particularly if there appears to be no recourse, may contribute to mistrust on the part of those who question the fairness and impartiality of the Health Department officials making those decisions. In order to reduce mistrust on the part of clients, the Health Department should prepare written guidelines on termination and appeal procedures involving an independent party. Clients should be made aware of the appeal procedure after it is developed.

Barriers to Service Could Lead to Frustration

Clients can only receive services under the Ryan White program when referred by their case manager. Case managers refer patients to available providers. Some Planning Council members suggested that minority clients might feel that they are forced to use providers with whom they are uncomfortable. Some clients reportedly prefer service providers located close by, while others may not want to use providers in their neighborhoods for fear of being seen obtaining services at an HIV/AIDS service provider.

Research has shown that minority patients face greater barriers to obtaining care than Caucasian patients. These barriers could lead to mistrust on the part of clients who feel that decisions about their care are unfair or are not in their best interests.

Greater incidence of new HIV/AIDS cases among minorities. In recent years, there has been a shift in the demographics of new cases of HIV/AIDS. While the percentage of new cases among Caucasians has declined, the percentage of new cases among African-Americans and Hispanics has increased. Exhibit 4 provides a comparison of total AIDS and new AIDS cases in Kansas City with a breakdown by race.

Exhibit 4. Total AIDS and New AIDS Cases by Race

Race/Ethnicity	Total AIDS Cases as of 3/31/98	New AIDS Cases 4/1/96 – 3/31/98
Caucasian	73%	57%
African-American	22%	36%
Hispanic	4%	6%
Asian/Pacific Islander	Less than 1%	Less than 1%
Native American/Alaskan	About 1%	0%

Source: Fiscal Year 1999 Grant Application.

Nationwide, while racial and ethnic groups account for only 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. While the epidemic is decreasing in some populations, the number of new AIDS cases among African-Americans is now greater than the number of new cases among Caucasians.[8]

The incidence of HIV/AIDS in Kansas City has followed the national trend. Although African-Americans constitute approximately 12 percent of the Kansas City area's population, according to the 1990 census, their proportion in the infected population today is around 33 percent. Hispanics are similarly over represented in the infected population. Currently, there are 1,334 clients enrolled in Ryan White case management, according to information from the Health Department. Exhibit 5 shows the breakdown of Ryan White clients by race.

Exhibit 5. Racial Breakdown of Ryan White Clients

Race	Kansas City Metro Population	Ryan White Clients
Caucasian	82%	61%
African-American	12%	33%
Hispanic	3%	5%
Native American	Less than 1%	1%
Asian/Other	2%	Less than 1%

Sources: Fiscal Year 1999 Ryan White Grant Application and 1990 U.S. Census.

It is estimated there are also 860 people who, although known to be HIV-positive, do not access Ryan White assistance. Demographic data indicate virtually no difference in the proportion of minorities affected by HIV/AIDS who receive Ryan White-sponsored treatment and those who do not. However, there are a significant number of African-American HIV/AIDS patients who never had their CD_4 count or have had no CD_4

[8] *Health Care Rx: Access for All*, (Rockville, MD: Health Resources and Services Administration, 1998), p. 2.

within the last two years.[9] This suggests some reluctance on the part of minorities to seek HIV/AIDS treatment. Exhibit 6 provides a comparison of racial breakdown of those not accessing Ryan White services.

Exhibit 6. Racial Breakdown of Area HIV/AIDS Patients Not Accessing Ryan White Services

Race/Ethnicity	Never Had CD_4 Count	No CD_4 Count in Last Two Years
Caucasian	157	341
African-American	154	144
Hispanic	24	32
Asian	2	2
Native American	0	3
Unknown	1	0

Source: Fiscal Year 1999 grant application.

Cultural barriers may limit minority access to health care. Studies by federal agencies have identified a number of reasons why minorities tend to experience barriers in access to health care. Minority HIV/AIDS patients may delay or refuse treatment for the following reasons:

- **Cultural background.** Minorities who are less comfortable in unfamiliar settings simply delay treatment rather than face the difficulty of negotiating their care with an agency unprepared to deal with their cultural needs.

- **Spanish language issues.** Many Hispanic HIV/AIDS patients value communication in Spanish, especially when discussing intimate and emotional matters such as illness and sex. Also, Spanish speaking people are more likely to be asked questions about their legal and citizenship status.

- **Sexual practices.** Minority men who have sex with men choose not to identify with gay communities and refuse treatment if that means an admission of being gay.

- **Clinical trials.** Experiences with previous clinical trials (such as the Tuskegee experiment) have led to perceptions that in trials patients are mistreated and their health care needs are neglected.

[9] CD_4 count is a blood test used to determine whether a person is eligible to receive Ryan White services. The CD_4 count establishes how far the disease has progressed by measuring the strength of the immune system. A healthy person has a CD_4 count of 1,400. CD_4 counts for full-blown AIDS patients are less than 200.

- **Indigenous medicine and healers.** Health-related beliefs and practices of some minority patients often are not understood and discouraged by caregivers with different cultural backgrounds.

- **Financial barriers.** Pre-existing conditions and lack of residency/citizenship lead to ineligibility for some services.

- **Institutional barriers.** Patients nationwide report that agencies care more about procedures and accuracy of information on forms than they do about a person's feelings or condition.

- **Limited access to planning and decision making arenas.** Some Planning Councils expect one Hispanic or Asian member to represent varied minority subgroups within the community, rather than appoint several individuals from each of those subgroups. There is also a bias toward established, mainstream organizations whose resources enable them to produce proposals viewed as technically superior to those generated by minority agencies.

- **Geographic barriers.** Most people want health care close to their residence and in familiar facilities. However, the stigma of HIV/AIDS has introduced other considerations, such as quality of care and confidentiality.[10]

Barriers to care may exist in Kansas City. Responses to our survey of the Planning Council indicate that 8 out of 19 members disagreed with the statement that all races have equal access to Ryan White services. A majority of respondents, 13 of 19, think that minority HIV/AIDS patients need race-specific services.

Interviews with Ryan White Planning Council members and case managers indicated that that they have identified and addressed some barriers. For example, Kansas City agencies use translators from Babel Communications for help with foreign-speaking clients, and Deaf Expressions for help when clients need to communicate in sign language. Guadalupe Center provides assistance with Spanish-English translation when requested. We did not hear any complaints from the case managers we spoke to about the quality of these services.

In addition, Ryan White case managers said that they realize the importance of indigenous treatments and try not to discourage their use if this is a patient's choice. The case managers we spoke with reported receiving cultural awareness training.

[10] Sources for the information regarding barriers to minority access to care can be found in Appendix C.

Comprehensive Study Needed

Concerns regarding patient confidentiality prevented us from interviewing or surveying HIV/AIDS patients to determine whether barriers to care exist in Kansas City and, if they do, what could be done to overcome them. In view of the information about nationwide barriers to minority access to Ryan White care, however, we suggest that the Planning Council consider funding a comprehensive study of how services are being delivered in the Kansas City eligible metropolitan area.

Such a study should evaluate the performance, quality, and responsiveness of all Ryan White service providers and determine the competency of providers to deliver services and to meet the specific needs of their clients in terms of customer satisfaction.

This study may focus on the following points:

- What are the systemic barriers to access to care in Kansas City?
- Are there barriers specific to Kansas City?
- Do different populations have equal access to care?
- Are different populations equally satisfied with the level of service at different providers?
- Are gaps in the continuum of care identified, including the linkage between prevention, education, counseling, testing, and treatment?
- What are the factors that influence people's choices of services at one site instead of another?

By studying the performance, quality, and responsiveness of the Ryan White services as well as barriers encountered by patients in obtaining those services, the Planning Council and the Health Department can identify the steps that need to be taken to alleviate the feelings of mistrust among the HIV/AIDS clients, service providers, the Health Department, and the Planning Council.

Recommendations

1. The mayor should direct the Ryan White Planning Council to prepare and present a curriculum and a timetable for orientation and training of its members in procedures and financial record review.

2. The health director should provide training to and regularly seek feedback from the Ryan White Planning Council members on the desired format of the Health Department's financial reports available for the Planning Council.

3. The commissioner of purchases and supplies should improve documentation of the bid selection process.

4. The commissioner of purchases and supplies should better communicate how the Ryan White procurement process works and should make the procurement results readily available to the public.

5. The commissioner of purchases and supplies should improve Ryan White procedural requirements in order to make the process more open and credible by following additional "best practices".

6. The health director with the assistance of the Law Department should create a written procedure for termination of Ryan White services. This procedure should provide Ryan White clients with a right for an appeal to an independent party. Clients should be made aware of the procedure.

7. The mayor should request the Ryan White Planning Council submit a timetable as to when the Planning Council plans to fund, hire a consultant to conduct a comprehensive study, and present a report about the delivery of Ryan White services in Kansas City, based on information obtained from HIV/AIDS patients. The study should address the issue of barriers to access to Ryan White services and customer satisfaction with service providers in Kansas City.

Appendix A

Ryan White Planning Council Members Survey Results

Planning Council surveys were mailed to all 36 members of the Kansas City area's Ryan White Planning Council as of October 1998. We received 19 completed surveys, a response rate of 52.7 percent.

1. The Health Department treats me with respect.

Strongly Agree	Agree	Disagree	Strongly Disagree
8	8	2	1

2. The Health Department is not responsive to my needs as a Planning Council member.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	3	8	8

3. I have received adequate Planning Council training to effectively perform as a council member.

Strongly Agree	Agree	Disagree	Strongly Disagree
2	7	8	2

4. I have ample opportunity to voice my concerns at Planning Council meetings.

Strongly Agree	Agree	Disagree	Strongly Disagree
7	9	2	1

5. My opinion does not have much impact on Planning Council decisions.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	4	9	5

6. I am comfortable with my level of understanding of Planning Council procedures.

Strongly Agree	Agree	Disagree	Strongly Disagree
5	8	6	0

7. I do not understand the financial information provided by the Health Department.

Strongly Agree	Agree	Disagree	Strongly Disagree
3	6	5	5

8. I am uncomfortable with the amount of conflict among Planning Council members.

Strongly Agree	Agree	Disagree	Strongly Disagree
2	6	9	2

9. HIV/AIDS sufferers of all races have equal access to Ryan White services.

Strongly Agree	Agree	Disagree	Strongly Disagree
4	7	5	3

10. Current Ryan White vendors provide adequate care for minority people living with HIV/AIDS.

Strongly agree	Agree	Disagree	Strongly Disagree
3	11	1	4

11. Minority people living with HIV/AIDS do not need race-specific AIDS service.

Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
2	3	7	6	1

12. Minority people living with HIV/AIDS should be served by minority service providers.

Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
3	1	10	3	2

13. The Kansas City, MO Health Department provides equal care to all races.

Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
6	8	1	3	1

14. The Health Department does not make enough effort to encourage minority vendors to bid for Ryan White contracts.

Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
3	3	9	2	2

15. Who do you represent on the Planning Council?

At-large service provider	1
Government agencies	4
HIV and Substance abuse community	1
HIV/AIDS community	6
No answer	1
Non-profit organizations	4
Non-profit organizations and Government agencies	1
Ryan White CARE Act Grantee	1

16. In your opinion, what are the positive and negative aspects of Ryan White care in K. C.?
Positive: One-stop care management, honest concern for mental health coordination of Titles I, II and III dollars, representative Council, active positive input (though they are often ignored), well-written grants to the feds, growing sensitivity to provide more services on the Kansas side (we are a bi-state EMA). Negative: need case management in African-American Community, too much money spent on buildings for HIV+s instead of rent assistance, health department can be paternalistic, council needs to train new members instead of letting them sink or swim, too much money is skimmed off by KCHD and case management ASOs for "administration" (out of 40,000 allotted for each case manager out of Titles I and II, they are paid at 26,000 with benefits. Where did the rest go? – Administration.) Failure to devise a reimbursement policy for positive expenses in attending meeting until mid-year.
Overall -- it is getting better, but there is still a lot of work to be done.
I know this response falls after the submission dead line: however, I only recently had an opportunity to respond. I feel strongly that KCHD manages the Title I program through control or omission of critical information to Planning Council members. Provider council members cannot voice their concerns or ask questions as they are intimidated by the grantee and fear the loss of their Title I contract. Representatives from other governmental agencies are discounted and questions voiced to the Title I grantee are ignored or labeled as hostile to divert attention from the issues the KCHD does not want to respond to. Minority members are treated in a condescending manner, their concerns shrugged off as ignorant. Their questions are based on ignorance, in its truest sense, because the KCHD refuses to provide information and respond to concerns. Often, expenditure data is based on projections. Actual expenditure data, the number of clients served and specifics regarding 1998 carry-over was not provided to the council. Carryover occurred in medications – this after KCHD – Title I had formed waiting lists and refused access to medications within fiscal year 1998. Don't Know [if current Ryan White vendors provide adequate care for minority PLWH] – quality assurance evaluation data is not provided to the council. Don't know [if Kansas City Health Department provides equal care to all races] data is not provided and concerns voiced by minority council members are discounted or ignored.
Positive: 1) good funding -- among the best per capita in the country. 2) Non-duplicative services. Negative: 1) low interest/motivation on the part of the positive community; 2) few minority providers, however, this is due to 1) no interest on the part of minority medical providers; 2) few minority candidates for ASO job openings, and 3) lack of training in minority candidates. In other comments: These questions seem prejudicial. You need a "middle ground" option: no answer or not applicable.
The positive aspect of the Council is that it works. The negative aspect is that members use the Council to grandstand and push personal agendas. What is needed is a leader who is neutral and fair.
Positive: Most generally, highly qualified providers. The Grantee (KCMOHD) tries hard to keep Planning Council informed. Negative: The inability for clients to access care/services more close to their home, especially those in the outlying areas.
Positive: Working toward bridging the gap of misunderstanding of client of how Ryan White works. Negative: Not enough care to the people of color (Hispanic). Cannot access housing for persons of color. In other comments: There is a strong need for a better understanding of other cultures and seek essential skills in working with patients/clients living with HIV. Each of us is a cultural being. When people of color interact with Western health care systems, their cultural values related to health, illness and help-seeking are often at variance with the values of the dominant system. Need to develop relationships with clients gathering of cultural information; discussing culturally sensitive issues related to HIV care; and negotiating culturally appropriate care plans.
Negative: 1) There still seems to be a good ol' boy[s] political atmosphere in terms of decision making, major money allocations, etc., 2) The leadership of the case management should emphasize client sensitivity, but it does not seem to do so; 3) Case manager turnover. Positive: 1) The Grantee is very knowledgeable; 2) housing assistance for PLWA's; 3) Inclusion of consumers in the Ryan White planning process (although more training needed).

The process is fair; there just isn't enough moneys.
Positive: Pays for life saving medicines for HIV/AIDS clients, as well as providing other assistance such as housing, food, emergency assistance. Negative: as a non-entitlement qualifying client I was offended when my caseworker asked for my personal financial information. If I, who require no assistance, am put through this humiliation, what of those who are requesting assistance. What amount of humiliation must they endure to receive this assistance!!! -- As if being HIV positive isn't enough.
Positive: 1) Council is now located not under the are and control of HIV Services; 2) New director of Health department -- Dr. Archer; 3) Good case management (GSP); 4) good treatment doctors at St' Luke Hospital - patients rights. Negative: 1) Biggest Negative - HIV Services Director and Case Management Overseer are very mean, negative, and rude to clients. I have observed it many times - (don't want to mention names, but will - J. Moore-Nichols, Barbara Beasley), 3) Health Department relationships to positive community, HIV Services (which reflects on whole Department); 4) Very poor relation of grantee to minority community; 5) HIV Services leadership negative qualities outweigh their strengths; Mental Health Counseling – want to get too much info at case management level (ie Jackson Co. Levy Requirements on info breaks rules of confidentiality between therapist and clients.); 7) Housing – AIDS people waiting (125+) and HIV people who need housing assistance can't get it; 8) Ryan White care in KC does not do enough to get people who are addicts the good treatment they need. KCCC is not a good treatment facility for HIV + gay addicted people. We must do better in getting them help – not counseling.
The Planning Council does as little as possible to fulfil the Grant Applications. The grant may look like all things are equal but they are NOT. What is said on paper is NOT done in practice. The Planning Council has too much Health Department interference. The Health Department does not encourage minority participation.
Positive: it provides a broad system of care that is responsive to client needs. Negative aspects of Ryan White are that there are a few very charismatic individuals who think they "know it all" and have their own agendas that they want to impress on everyone. The demographics of HIV are changing slightly to significantly and we need to address this. However, the balance of those infected has not changed so dramatically that we need to make radical changes. The care of those infected must be balanced with need and availability of funds.
Positive Aspects: 1) Access to care – individuals without third party payer (insurance or Medicaid) have a choice of providers and have access to care when they otherwise would not; 2) Continuum of care -- broad range of services available which support access to care and quality of life; 3) Integrated care system – all funding sources (Ryan White Title I, II and III, ADAP, city and state general funds, private sources) collaborate in the design and implementation of services so there is no duplication; 4) Community input -- there is ample opportunity for the communities most affected to provide input into the design and implementation of services. Negative Aspects: Complexity of the process -- The Planning Council process is the first time in the history of public health that the community has been given the legislative authority, indeed it is mandated in the Ryan White CARE Act, to identify needs, determine priorities and set allocations. It has been a learning process for both the community and the health department. And it remains a learning process for new planning council members. It is a difficult process to understand because there are so many factors that must be considered. Many of the difficulties experienced by the Planning Council can be attributed to a lack of understanding of the roles and responsibilities of bot the Planning Council and the Health Department. Time – To effectively contribute to Planning Council process, members must invest large amounts of time. Members must be willing to invest a great deal of time to learn about the process and then to participate in meetings, sub-committee meetings, and task forces. For many members this precludes their effective participation and for some it has resulted in resignations from the council. In other comments: I have been on the PC long enough to know what it's about but there is no training program. One is in development.

Appendix B

Vendor Survey Results

Vendor survey questionnaires were distributed by mail to 41 vendors who attended pre-bid conferences for Ryan White contracts in 1997. We received 21 completed questionnaires, a response rate of 51.2 percent.

1. Health Department staff was helpful in familiarizing me with the process of bidding for city contracts.

Strongly Agree	Agree	Disagree	Strongly Disagree
6	12	3	0

2. Purchasing Division staff was helpful in familiarizing me with the process of bidding for city contracts.

Strongly Agree	Agree	Disagree	Strongly Disagree
5	11	5	0

3. The Request for Proposal I received was easy to understand.

Strongly Agree	Agree	Disagree	Strongly Disagree
4	10	4	3

4. The pre-bid conference(s) that I attended answered all of my questions.

Strongly agree	Agree	Disagree	Strongly Disagree
4	12	4	1

5. My bid(s) were evaluated fairly.

Strongly Agree	Agree	Disagree	Strongly disagree	Did not bid
6	7	3	1	4

6. Did you seek Ryan White contracts with the city of Kansas City, MO before 1997?

Yes	12
No	9

7. How did you find out the city was seeking proposals in 1997?	
Received a request for proposal.	12
Saw a notice in a newspaper/magazine.	1
Received a call from the city/local area contact.	2
Received an RFP and a call.	2
Through RFP listing via e-mail.	1
Received a notice of a pre-bid conference.	1
Received an RFP and through continued contact.	1
Another vendor told me.	1

8. Did your agency submit a bid to provide Ryan White Services in 1997?	
Yes	17
No	4

9. If no, why not?	
1. Did not adequately understand the process. Did not feel my bid would be fairly reviewed.	1
2. Did not intend to bid.	1
3. KCHD wanted to bring my kitchen up to code, while we are building a new state-of-the art facility.	1
4. We could not provide required vehicles.	1

10. If you did submit bids, did you receive any Ryan White contracts as a result of your bid submissions in 1997?	
1. Yes	15
2. No	2
3. Did not bid	4

11. How did you learn the results of the bid review process?	
1. I did not bid.	3
2. I bid and received city notification by mail.	14
3. I bid and received city notification by mail and by phone.	2
4. No answer.	2

12. After the contracts were awarded, did you attempt to review the bid evaluation decisions?	
1. Yes	7
2. No	12
3. No answer	2

13. In your opinion, who makes the final decision to award a contract to a particular agency?	
Purchasing staff. Health Department staff. A group of representatives from different organizations. The evaluation team reps are listed in the RFP.	1
Health Department staff	5
Ryan White Planning Council	1
A group of representatives from different organizations	3
Health Dept and a group of reps from different organizations	1
Purchasing staff. Health Department staff. Ryan White Planning Council staff.	1
Combination of health Dept staff and advisory board	1
Purchasing staff. Health Dept staff, and a group of reps from different organizations	1
Do not know	5
No answer	2

14. In your experience, what are the positive and negative aspects of Ryan White vendor selection in Kansas City?
Hate HIS Crooked Company. Badly Law.
I only have positive comments about the RW vendor selection process as it currently stands. As a vendor I am given all of the information which I need to complete the process at the pre-bid meeting. Both Margene Bahm and Judy Moore-Nichols (or appropriate staff members) READ through the RFP item by item. At any point in the process we may ask questions to get clarification. If questions are asked for which an answer is not available, an addendum with the questions and the answers are sent out promptly. We are also informed that we may ask questions (through a certain date) if submitted in writing to Ms Bahm. In situation where I was awarded a contract, I was verbally informed as well as informed in writing. In situations where I didn't receive a contract, I have been able to review the evaluation reviews in a timely manner. This is one of the best RFP processes which I have worked with. The level of information given as well as the amount of cooperation from the Health Department and the City Purchasing Department is phenomenal. I would not support any change in the process as it is already at a highest professional level possible. In other comments: Margene Bahm is excellent. City office was very helpful in letting me review evaluation decisions.
The positive aspects are that the vendor selection process allows fairness with competitive bidding. On the negative side the initial application process is quite cumbersome and long.
The process on the outside seems fair. But, internally, I think everyone knows the Health Department picks who it wants to contract with.
Negative: the difficult and confusing RFP bid proposal is a very negative aspect of Ryan White vendorship. Extreme amount of paperwork. The feeling of political favoritism. Positive: good support staff help from Grantee agency, I.e. Judy O'Donnell, Georgia Nixon are very knowledgeable and helpful.
For the past two years we have bid and received a contract. We were always treated fairly and with respect. We enjoy our relationship with the city of Kansas City as well as the Health Department and the Ryan White case managers.

I really can't answer, as my institution is unique.
There may be a need for more involvement of Planning Council at an earlier stage in selection/project execution process.
Really liked the pre-bid conference to have all my questions answered.
The review process is made up with individuals who all have bias toward agencies. There is not an unbias[ed] objective review process. Perception is agencies that are liked get $.
The city, in contracting this service, does not avail itself of all price opportunities. Other city/county agencies use existing group purchasing opportunities for manufacturer contracting and then use alternative distribution methods. Wholesale drug distribution centers are out of the loop in your process, leaving retail/chain operations as the only outlet. Unfortunately, these may be less desirable for product cost options but seem to be the only recourse for the distribution/tracking requirements.
In other comments: We would like to re-bid after our new facility is complete. We would be able to serve HIV/AIDS population then to include a pantry, on-site feeding, and evening meal delivery service. We plan moving February 1999.
Purchasing staff, specifically Margene Bahm, has no "real" knowledge of HIV/AIDS, interventions, needs of minority communities, etc. Often times [a] "group of representatives" utilized have their own personal agendas or are friends with certain bidders which does not allow them to evaluate all bidders fairly. After we were denied, I actually went to purchasing office to review all applications to determine if our application was way off base. It was not. Our proposal was better than most yet not funded. Why? I don't know. We clearly had the agency and staff experience and also able to meet the needs of a "special" population. They ended up giving contracts to the same old providers -- including one who always calls us to help with their Spanish-speaking only clients. I guess they forget that we speak English too!
Process felt unusual at times, as though the decisions were made before the proposals were evaluated. Positive aspect was having the opportunity to review other agency proposals. Negative aspect that numerous times it seemed like RFP's were simply recycled and that no one paid much attention to what the Health Department was asking for in the RFP.
Positive: advance notice; continuation of same process; participation of committee to review bids. Negative: lack of communication between contract office and program office of KCHD; sometimes hard to get answers.
I thought process was very competitive. Everything we were told was informative. I thought the process was very fair and not biased. The best bids along with the best services and location decided the final outcome. I thought it was fair to have at least 2 retail and 2 hospitals included allowed for patient choice.

Appendix C

Bibliography

The following sources were used to identify cultural barriers which could potentially limit minority access to health care:

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Appendix D

Health Director's Response

CITY OF FOUNTAINS
HEART OF THE NATION
KANSAS CITY
MISSOURI

Health Department

Director's Office

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DATE: March 9, 1999

TO: Mark Funkhouser, City Auditor

FROM: Rex Archer MD, MPH, Director of Health

SUBJECT: **Report on Ryan White Funding Equity**

The Health Department wants to thank the city auditor and his staff for the very professional and thorough performance audit. This neutral audit is the factual response to questions raised. We are pleased that the audit covers two years and over four million dollars of the Ryan White CARE Act, and "did not identify any areas in the operation of the program in which it appeared that clients or service providers were being treated unfairly". The Ryan White CARE Act is unique legislation in that volunteer appointees conduct the needs assessment, establish priorities, allocate funds to priorities, and evaluate the administrative mechanism for delivery of CARE services to persons with HIV/AIDS. Neither the City Council nor the Health Department can change, veto, or overrule the decisions of the Ryan White Planning Council. The Health Department is responsible for awarding contracts for the delivery of services. This complex process requires extensive orientation and ongoing training for the volunteers to understand their role and the requirements of the legislation. We concur that orientation and on-going training for Planning Council members is continually needed, and a better understanding of complex financial information is crucial, especially since the Planning Council members serve one year terms. Since the leadership as well as membership evolves over time, training and orientation will continue to play a critical role.

1

The Health Department wants to also thank the Purchasing and Supplies Division of the Finance Department for their professional assistance. We concur that the detailed process of points obtained by each section of the proposal should be open to the public as well as the total points received by each proposal for services. Minutes should also be taken and the increased documentation will support the integrity of the award process. The Health Department and Division of Purchases and Supplies already include most of the "best practices" and concur that all of those identified can be implemented.

Part of the development of the Ryan White CARE Act training for clients and Ryan White Planning Council members must stress that Ryan White is not an entitlement, but is based on assessed need of those who are HIV positive and meet income criteria.

Written appeal procedures need to be finalized.

The Health Department, through named HIV positive reporting and named reporting of CD4 counts has monitored, analyzed and projected trends. The newly diagnosed cases among whites and non-whites have decreased since the early 1990s. The decrease in new cases of HIV infection among whites is larger than among non-whites. The Ryan White Planning Council strives to demographically represent those who are infected; and the Health Department, through its subcontractors, strives to provide sensitive and cost-effective care to all who are infected throughout the eleven county area, with over 1,300 clients currently enrolled. Now, forty-six percent of the case managers are minority including two who are Hispanic. Two are bilingual. The Health Department conducted an analysis in spring of 1997 of those not in care and proposed a marketing campaign, in summer of 1997, which brought ninety new clients into care. Barriers to care exist for many, if not most, HIV/AIDS clients because of the fear of isolation and discrimination.

Whether white or non-white, heterosexual, homosexual, or bisexual, male or female, many still fear public identification because the main mode of transmission is unprotected man-to-man sex. Minority men who have sex with men are often even more isolated and fearful of accessing mainstream care. The Ryan White Planning Council, Health Department, AIDS service organizations, health centers, hospitals, etc., are continually trying to reduce and eliminate barriers to care and would work with the Ryan White Planning Council as they undertake a comprehensive study.

FINDINGS AND RECOMMENDATIONS

The Findings and Recommendations accurately reflect a complex program and emphasize the need for comprehensive and continuous training to reinforce the understanding of the roles of the Ryan White Planning Council and grantee.

As the Ryan White Planning Council began in 1993, its committees were structured along the lines of the categories of services, and 40% of the voting members were HIV positive. As the volunteer's expertise of the Ryan White Planning Council developed, they grew in independence and restructured the committees by needed process such as:

- Finance
- By-Laws
- Needs Assessment
- Membership
- Evaluation and Quality Assurance
- Executive
- P-Care, a committee of the HIV positive community.

During the restructuring the orientation process was not a top priority, and was not maintained. This last year, 1998, restructuring was completed, and in January 1999, a full day orientation was held for new and existing members. In addition, a finance committee was established. The grantee's financial reports and recommendations go to the finance committee and the finance committee makes a recommendation to the Ryan White Planning Council. The Ryan White Planning Council has made every effort to have full

representation of HIV positive clients and minorities on every committee. All Ryan White Planning Council meetings and committee meetings are open to the public, and subject to the Sunshine Law.

The proposals submitted through the Purchasing and Supplies Division of the Finance Department can be expanded by including all of the "Best Practices" enumerated and by opening to the public the details of each of the 20-25 categories upon which each proposal is rated, as well as the current practice which is to have the total points open to the public. Furthermore, the grantee will assure to continue to have HIV positive persons and proportionate representation of minorities on peer review panels. Although not required by HRSA, the Ryan White Planning Council conducts annually a needs assessment which is to comprehensively assess barriers to care. The Health Department concurs that an additional, separate, comprehensive study of barriers to care is needed and could be added to the existing needs assessment plan.

MISTRUST COULD RESULT FROM A LACK OF UNDERSTANDING

Peer review panels that evaluate Requests for Proposals are persons with no conflict of interest. They are not allowed, nor are family members allowed to be a board member or staff of any agency competing. If HIV positive, a panel member may be a client of the agency being rated.

Planning Council Membership Complies with Federal Requirements

The wide range of persons, and views that are representative on the Ryan White Planning Council requires an extensive on-going dialogue and training for the members. This is a unique experiment in public administration, that invests the decision making power for the allocation of funds in a body of non-elected volunteers. Ryan White Planning Council membership complies with HRSA's requirements. The legislation requires a minimum of 25% HIV positive voting members, and that the demographics of the Ryan White Planning Council reflect the demographics of the disease locally.

Planning Council members expressed uncertainty about their role. The Planning Council conducted a full day orientation for newly appointed and existing members in January 1999. The orientation and on-going training is necessary to clarify process and roles.

In addition to the recommendations to increase Planning Council orientation, training, and clear understanding, the Health Department would recommend a semi-annual meeting with the Mayor, Health Department, and the leadership of the Planning Council to clarify processes and clear up any misunderstandings. This may be especially crucial with a new Mayor taking office in April and new appointees for the Ryan White Planning Council anticipated in July.

PROCUREMENT PRACTICES COULD APPEAR UNFAIR

The Health Department concurs to release to the public the details of each RFP rating, in addition to the point totals of each RFP, and minutes of meetings. After the pre-bid conference, questions are received in writing only, with a copy of each question and written answer sent to all who attend the pre-bid. No contact with Health Department staff is allowed except by written questions through Purchasing. This assures that all interested parties have the same information.

Contract Award Procedure Could Contribute to Mistrust. Three agencies lost their initial bids for Ryan White Case Management in 1997. Two of those agencies are minority CBOs as defined by HRSA, one was not. The two minority agencies did receive Education/Prevention contracts through Purchasing. Three minority agencies were awarded case management contracts and also Education/Prevention contracts. The 1997 peer review panel consisted of seven members:

3 Nurses	3 Case Managers	1 Federal expertise Case Manager	
1 Male	6 Females	2 White	5 Non-white

5

The peer review panel was established in 1997 and led by a minority female. The case management RFP's did not identify the names of agencies—they were blacked out for the peer review panel. The Health Department concurs that all of the "best practices" can be adopted.

Lack of Accountability over Contract Award Decisions. The Health Department concurs that minutes should be made available and that the 20-25 categories that are scored should be made public, as well as the total points for each RFP. In addition, the record should indicate how a cut-off point, such as 50% was established. The openness will strengthen the integrity of the process.

Unsuccessful Bidders not notified. The Health Department concurs that unsuccessful bidders should be notified, and that process was implemented by Purchasing in 1998.

Grievance procedures are adequate. As required by HRSA, grievance procedures include appeal to the commissioner of Purchasing and subsequent appeal to an independent binding arbitrator appointed by the Mayor. HRSA required the appeal to a binding arbitrator to remove the awarding of a contractor from the political process while providing for a decision review independent of the grantee. The grantee's grievance procedures are also required to be approved by HRSA, and Kansas City's have been approved.

Procurement Procedures Should Be Strengthened

Four out of seven "Best Practices" have been in effect, and the Health Department concurs that the other three should be implemented.

- *"Competitive negotiation should be used for medical and social services contracts. The procedure allows an award to the contractor with the best combination of price, experience, and quality of service delivery. Also, if the procurement official and the evaluation committee determine after an*

initial evaluation of proposals that negotiations with bidders are advantageous, all bidders whose proposals are identified as acceptable must be given opportunity to negotiate and revise their proposals." Always has been in effect through Purchasing.

- *"Scoring panels should have an odd number of members, with the procurement official deciding who may sit on the committee. The recommendation of the committee is purely advisory and the procurement official should make the final decision."* The Health Department concurs with the recommendation for odd numbers of members.
- *"Members of the evaluation committee should be required to sign a conflict of interest/confidentiality statement before receiving copies of proposals to ensure the integrity of the procurement process."* In effect since 1998.
- *"To ensure that the evaluation panel members understand their roles and responsibilities, they need one or more training sessions."* Currently in effect. This training was instituted in December 1998, and will be continued.
- *"The employment of an evaluation committee should be structured, formal, and a matter of record. Committee deliberations should be recorded. Score sheets and minutes of evaluation committee meetings should become a part of the procurement file. All procurement records should be available for public inspection upon request. The documentation of the procurement decision should be sufficient to allow competing bidders, the press, and the auditors to see the basis for the award decisions."* The Health Department concurs. Minutes will be taken and details of points by category by reviewer should be open to the public.
- *"Purchasing officers should participate on the evaluation panel only as ex-officio members. Their non-voting status is necessary because their possible future roles as mediators of contract disputes, enforcers of contract provisions, and initiators of litigation against a contractor may require them to render impartial decisions."* The Health Department concurs with this recommendation.

- *"The use of Title I CARE Act funds for delivery of particular services by the Health Department should be based on direction from the Evaluation Committee and/or an objective review process. This procurement should be subject to a public process if there are other entities in the community that could provide the priority service."* Since the program began the process has been that the Ryan White Planning Council establishes priorities of categories, and allocates dollars to categories. The grantee has been using an objective review process through Purchasing since 1995. The additional best practices should reduce misunderstandings. We support further documentation regarding why the Health Department provides Medicaid case management, and one regular case management position.

MISTRUST COULD BE THE RESULT OF PERCEIVED BARRIERS TO CARE

The Health Department concurs that written termination or appeal procedures should be developed and will work with the Planning Council as they undertake a comprehensive evaluation of services currently being provided. The written process for appeals needs to be formalized in conjunction with the law department, and incorporate appropriate safe guards under EEOC and ADA.

Barriers to Service Could Lead to Frustration

The Health Department and Planning Council conducted a client satisfaction survey several years ago, and after discussions with the Evaluation and Quality Assurance committee of the Planning Council, the grantee is again this year conducting the client satisfaction survey. This should assist in identifying any barriers.

Greater incidence of new HIV/AIDS cases among minorities. While the actual number of both white and non-white new diagnoses of HIV infection peaked in 1989 and 1990 respectively, non-whites are

disproportionately affected (attachment 2). The decrease in new HIV cases has not dropped as dramatically in the non-white as in the white community.

Thus in 1989, out of 386 new HIV diagnosed cases, non-whites accounted for 115, (30%). In 1998, there were 71 non-whites out of 118 new diagnosed cases, (60%). Although the actual number has decreased (from 115 to 71), the percentage of new cases who were non-white has doubled (from 30% to 60%). The second wave of the HIV/AIDS epidemic is minorities and women (Attachment 2).

The 1997, HIV and AIDS Case Rates, which include all HIV infection for the Kansas City EMA are less than the AIDS case rates in the United States which does not include all HIV infection, only those cases that have progressed to AIDS.

1997	**Kansas City***	**United States****
White	19.2	10.2
Black	30.12	83.7
Hispanic	23.61	37.7
Asian/Pacific Islander	11.40	4.5
American Indian/Alaskan	11.40	10.4
TOTAL	20.49	22.3

*HIV & AIDS Cases (Attachment 4 & 5)
**AIDS cases, not including HIV

The Health Department initiated a study in 1998 of the HIV infected persons who were not accessing primary care as determined by not having a CD4 count done. The Ryan White Planning Council allocated $40,000 to a marketing campaign to bring more HIV positive persons into care. The marketing campaign brought ninety additional people into care. (Attachment 3 a-c)

Cultural barriers limit minority access to health care. Cultural background, language issues, sexual practices, clinical trials, financial and institutional barriers, limited access to planning and decision making arenas and geographical barriers can all limit minority access to health care.

In the greater Kansas City EMA, we have been providing Ryan White Title I services since 1994 and have worked to achieve a sensitive delivery system. We have:

I. Ten (10) African American and two (2) Hispanic American/Latino case managers, twelve (12) out of 26, (46%) minority case managers.

II. Two (2) case managers are bilingual.

III. Primary care services are offered at a variety of health centers, hospitals, and health departments where a client has a choice of visiting a clinic that is primary HIV/AIDS, or a more general setting. Many minority men who have sex with men do not consider themselves gay, or homosexual; many minority men who have sex with men also have sex with women. While many of these minority men who have sex with men and women consider themselves as heterosexual, society's definition may classify their behavior as bisexual.

Minority men and women may feel even more isolated and discriminated against than gay, white men with HIV/AIDS. In addition, many minority agencies, and groups, are not accepting of homosexual and bisexual men. Therefore, minority men who have sex with men may not have access to even traditional minority services.

Some minority men with HIV/AIDS would rather access treatment at a traditionally "gay" organization, than be seen at a traditional minority agency, and be asked why they need health care. Layered upon that issue, is the history with the Tuskegee experiment in which minority group leaders were also deceived.

In the Kansas City EMA, 37.8% of the people living with HIV/AIDS are minority, (Attachment 3c) and 38.9% of the people enrolled in Ryan White case management are minority, (Attachment 1).

Financial Barriers. Financial barriers, the need for housing, substance abuse counseling, mental health counseling, food, and emergency assistance all contribute to the perception that many HIV infected people are not sick or have more pressing needs. Non-citizen clients may also be concerned about being deported if they access medical care. In addition, migrant workers may not stay in one area to access care.

Institutional Barriers. As with any Federal program the requirements for paperwork may be perceived as a barrier. Ryan White, by law, is the payer of last resort, so the case managers assist the client in applying for Medicaid, food stamps, SSI, SSDI, and insurance. Ryan White is only for low-income persons who have no other way to access services.

Limited accesses to planning and decision making arenas. The Ryan White Planning Council has continually been striving to increase minority voting members. The benchmark HRSA uses for racial demographic representation is AIDS cases in the last two years, from April 1, 1996, to March 3, 1998.

HRSA benchmark for Kansas City

White 57%
Non-white 43%

Ryan White Planning Council as of 9-1-98

White 63%
Non-white 37%

Ryan White Planning Council as of 1-1-99

White 60%
Non-white 40%

The composition of the Ryan White Planning Council complies with federal requirements and reflects the demographics of the AIDS epidemic in the Kansas City EMA. HRSA has accepted the representation. The Health Department has continued to encourage the Ryan White Planning Council to recruit minority members.

Geographic barriers. These barriers exist throughout the eleven county area. However, as discussed some feel the need to travel away from their neighborhood for treatment.

Comprehensive Study Needed. The Ryan White Planning Council conducts a comprehensive needs assessment each year and the Health Department concurs with the recommendations for a comprehensive study to evaluate the performance, quality and responsiveness of all Ryan White providers including customer satisfaction.

RECOMMENDATIONS

1. *"The Mayor should direct the Ryan White Planning Council to prepare and present a curriculum and a timetable for orientation and training of its members in procedure and financial record review."* Concur—The Ryan White Planning Council had an orientation program from 1993 to 1997, during reorganization the orientation program lapsed. The Ryan White Planning Council has already prepared a curriculum and conducted orientation training in January of 1999. This training should be on going. In addition to the recommendations to increase Planning Council orientation, training, and clear understanding, the Health Department would recommend a semi-annual meeting with the Mayor, Health Department, and the leadership of the Planning Council to clarify processes and clear up any misunderstandings. This may be especially crucial with a new Mayor taking office in April and new appointees for the Ryan White Planning Council anticipated in July.

2. *"The Health Director should provide training and regularly seek feedback from the Ryan White Planning Council members on the desired format of health department's financial reports available for the Planning Council."* Concur—the Health director has met with Planning Council members, in the fall of 1998, and through the finance committee receives the desired format of reports to the Planning Council. That dialogue should continue.

3. *"The commissioner of purchasing should improve documentation of the bid process."* Concur—more details including minutes of peer review panel meetings and the detail points scored by category should be open to the public. Pre-bid conferences—since 1995, non-selected 1998.

4. *"The commissioner of purchasing should better communicate how the Ryan White procurement process works and should make procurement results readily available to the public."* Concur—a technical assistance training for new city vendors and the procurement results, including responding to non-selected proposals should be continued.

5. *"The commissioner of purchasing should improve Ryan White procedural requirements in order to make the process more open and credible by following additional "best practices."* Concur--All best practices should be implemented. Four out of seven best practices are currently in place. The other three should be implemented immediately with the cooperation of the Purchasing and Supplies division and the Mayor's office.

6. *"The Health director with the assistance of the law department should create a written procedure for termination of Ryan White services. This procedure should provide Ryan White clients with a right for an appeal to an independent party. Clients should be made aware of the procedure."* Concur—The Health Department will begin working with the law department for written procedure for termination of Ryan White services.

7. *"The mayor should request the Ryan White Planning Council submit a timetable as to when the Planning Council plans to fund, hire a consultant to conduct a comprehensive study, and present a report about the delivery of Ryan White services in Kansas City, based on information obtained from HIV/AIDS clients".* The study should address the issue of barriers to access to Ryan White services and customer satisfaction with service providers in Kansas City." Concur—The Health Department concurs and hopes the timetable will allow for the comprehensive study to be completed by July in order to be included in the Ryan White Title I competitive grant application.

Again, the Health Department wants to thank the city auditor and his staff for their very professional and thorough performance audit. The Health Department will continue to strive to accomplish the recommendations put forth in this audit, and improve on the "best practices" suggested.

Attachment 1

Kansas City EMA Case Manager Caseloads by Ethnicity and Gender

Agency	Case Manager	Race/Sex	Degree	Caucasi	African-	Hispanic	Native A	Asian/P.	Other	Male	Female	Transge	Total Clients
Good Samaritan Project	vacant			31	18	5	0	0	0	50	4	0	54
	Rhonda Simmons	C/F	BSW	37	9	0	0	0	0	44	2	0	46
	Marla Jarrett-Williams	AA/F	MSW	52	12	7	0	0	0	66	5	0	71
	Dara Gill-Fletcher (s)	AA/F	MSW	11	8	0	0	0	0	17	2	0	19
	Gwen LaViolet	AA/F	BSW	27	22	2	2	0	0	44	9	0	58
	Lisa Arroyo	H/F	BSW	41	14	2	1	0	0	49	9	0	58
in training	Carlia Waite	C/F	MSW	9	4	1	0	0	0	12	0	2	14
	Jules Wilson	AA/M	BA	31	10	1	0	0	0	41	1	0	42
KC Free Health Clinic	vacant			21	4	1	0	0	0	26	0	0	26
	Laurie Cook	C/F	BSW	46	9	3	0	0	0	54	4	0	58
	Jonna Leasure	C/F	BSW	54	5	3	1	0	0	62	1	0	63
	Amber Rossman	C/F	BSW	34	16	3	1	0	0	52	2	0	54
	Legatha Fuller	AA/F	BSW	4	4	0	0	0	0	8	0	0	8
KC Health Dept	Barbara Beasley (s)	AA/F	RN/MA	5	12	0	0	0	0	14	3	0	17
	Ernestine Bowren *	AA/F	BSW/MA	8	1	0	0	0	1	8	2	0	10
	Darrelee Williams	AA/M	BSN	14	44	2	0	0	0	50	10	0	60
Jackson County HD	Dan Clark	C/M	BSW	54	0	1	0	0	0	47	8	0	55
	Christina Czarev	C/F	BSW	7	4	1	0	0	0	11	1	0	12
Johnson County HD	Natalie Adams	C/F	RN/BSN	62	8	4	0	1	5	61	19	0	80
	Karen Hughes	C/F	BSW	7	1	0	0	0	0	5	3	0	8
Leavenworth County HD	Blaine Saunders	AA/M	BSW	14	3	0	0	0	0	16	1	0	17
Samuel U. Rodgers Heal	Richard Wright (bilingu	C/M	MA	31	24	3	0	0	1	47	11	0	58
Swope Parkway Health	Carla Gibson	AA/F	BA	15	45	0	0	0	0	47	13	0	60
Trinity Lutheran Hosp.	Jeannette Braun	C/F	MSW	39	13	0	0	0	1	46	7	0	53
Truman Med Ctr West	Maria Pulido	H/F	BSW	17	35	5	0	0	0	40	16	1	57
	Mark Stowell	C/M	MSW	22	36	7	0	0	0	45	20	0	65
KU Med Ctr	Wendy Benjamin	C/F	BSW	30	20	1	0	0	2	47	6	0	53
YWCA of KC, KS	Ingrid McDonald	C/F	BSW	40	32	2	1	0	2	59	18	0	77
Totals by Column	26 positions filled, 2 vacant			**763**	**413**	**54**	**6**	**1**	**12**	**1068**	**177**	**3**	**1253**

Clients are 60.1% Caucasian and 38.9% minorities

State of Missouri Employees

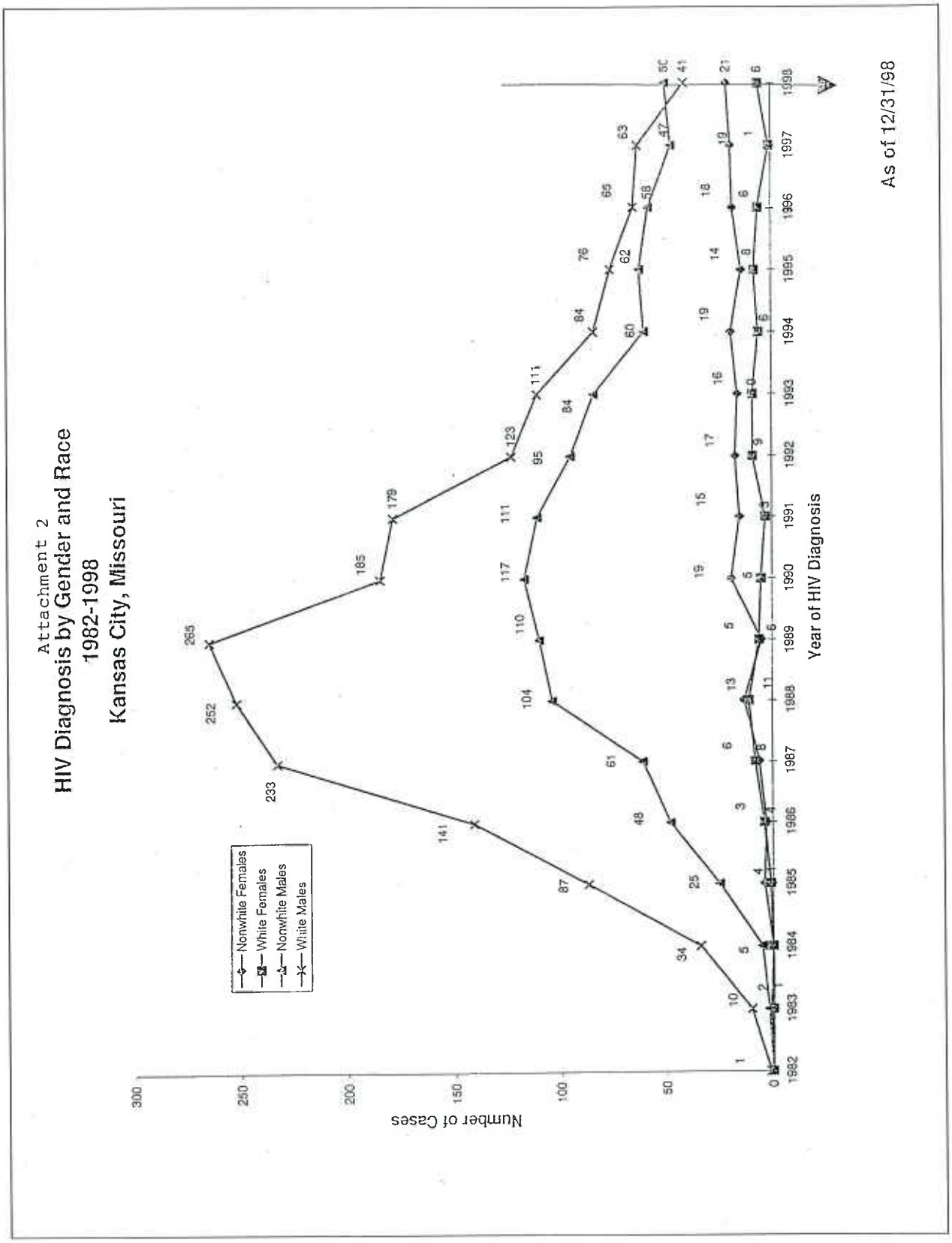
St Joseph/Buchanan Cty	Rita McElhaney	C/F	BS	40	6	0	0	0	1	38	9	0	47

46% minority Case Mgrs(12/26), 54% Caucasian Case Mgrs(14/26)

* Ernestine Bowren co-case manager for additional 5 clients (s)= supervisor

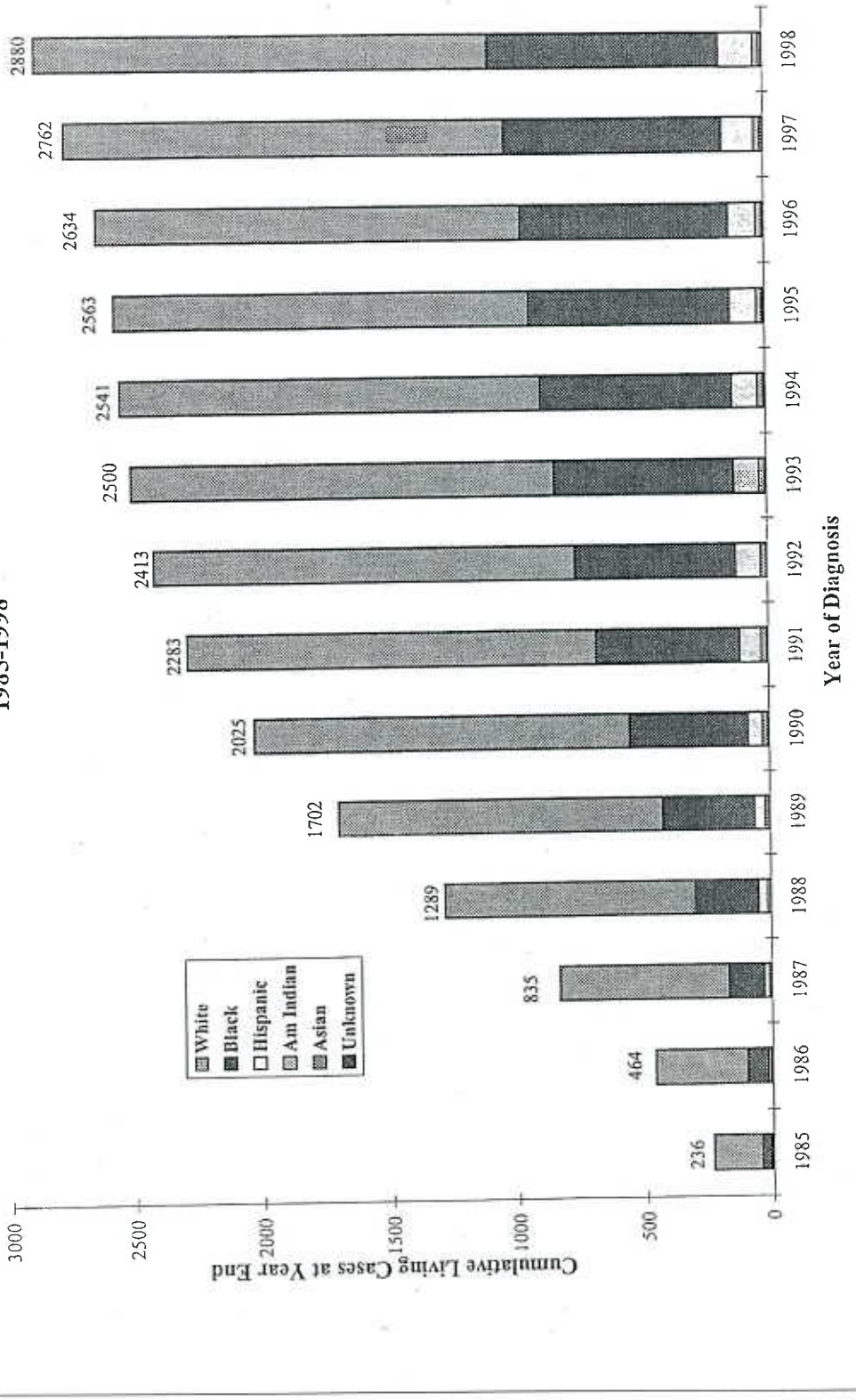
Grand Total **1300**

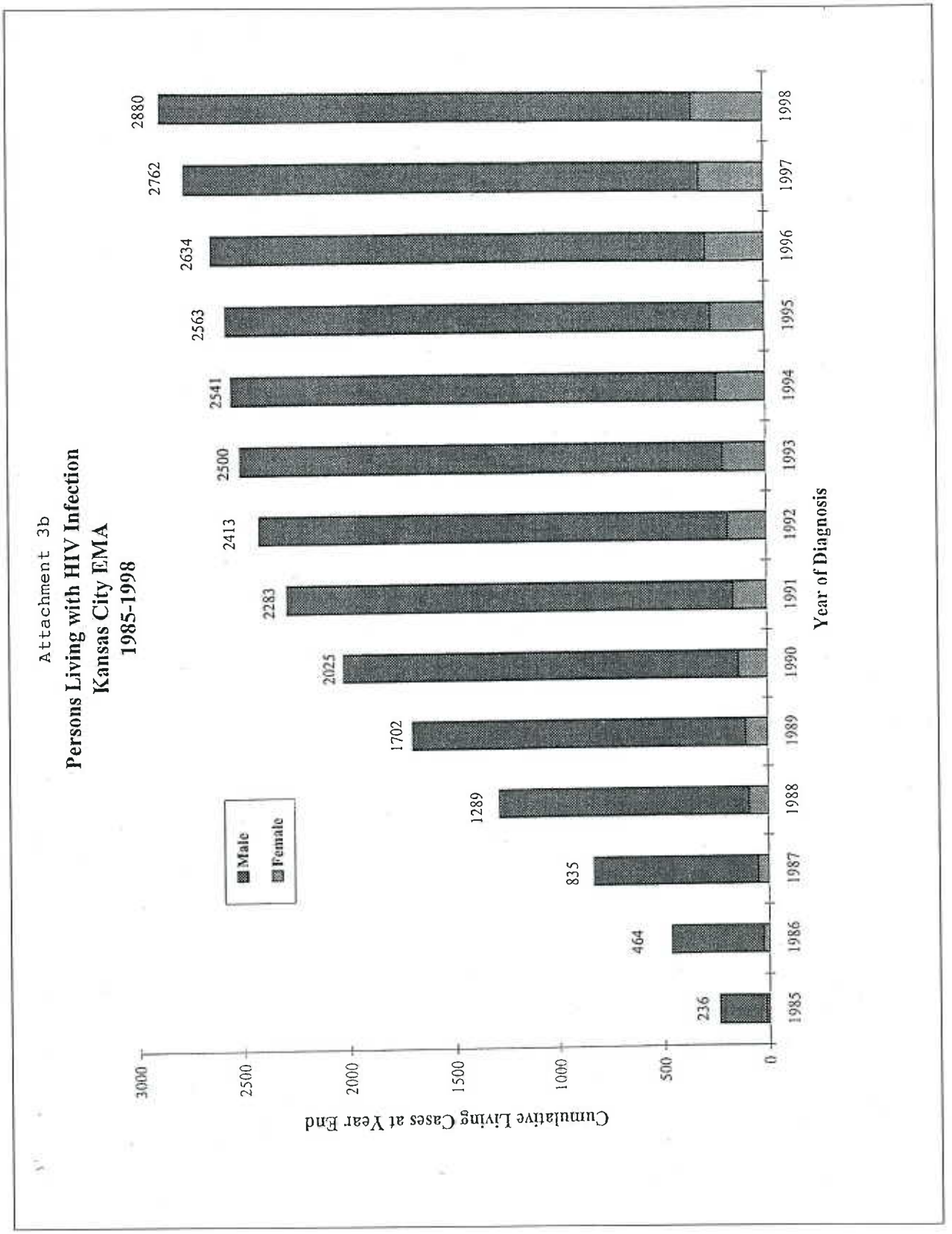
Prepared by HIV Services Program 2/23/99


Attachment 2
HIV Diagnosis by Gender and Race
1982-1998
Kansas City, Missouri
Nonwhite Females
White Females
Nonwhite Males
White Males
Number of Cases
Year of HIV Diagnosis
As of 12/31/98

Attachment 3a

Persons Living with HIV Infection
Kansas City EMA
1985-1998




Attachment 3b
Persons Living with HIV Infection
Kansas City EMA
1985-1998
Male
Female
Cumulative Living Cases at Year End
Year of Diagnosis
0
500
1000
1500
2000
2500
3000
236
464
835
1289
1702
2025
2283
2413
2500
2541
2563
2634
2762
2880
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998

Attachment 3c

Persons Living with HIV Infection by Race and Gender
Kansas City EMA
1985-1998

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Female	15	28	51	91	106	136	159	184	205	231	257	278	307	341
Male	221	436	784	1198	1596	1889	2124	2229	2295	2310	2306	2356	2455	2539
Total	236	464	835	1289	1702	2025	2283	2413	2500	2541	2563	2634	2762	2880
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Asian	0	0	0	0	3	5	5	4	5	7	10	8	11	12
Black	36	81	139	251	365	469	567	634	709	754	790	820	857	911
Hispanic	5	12	22	35	42	60	85	99	101	101	107	110	129	138
Am India	3	7	10	15	17	21	23	23	23	24	21	23	25	24
Unknown	0	0	0	0	0	0	0	0	1	1	1	1	1	2
White	192	364	664	988	1275	1470	1603	1653	1661	1654	1634	1672	1739	1793
Total	236	464	835	1289	1702	2025	2283	2413	2500	2541	2563	2634	2762	2880

37.8% of those living with HIV/AIDS are minority, as of December 31, 1998.

Attachment 4

HIV and AIDS Annual Case Rates for Kansas City EMA
As of 11/30/98

	White		Black		Hispanic		Other		Total	
	# Cases	Rate	# Cases	Rate	# Cases	Rate	# Cases	Rate	# Cases	Rate
1983	2	*0.16*	0	*0.00*	0	*0.00*	0	*0.00*	2	*0.14*
1984	12	*0.98*	1	*0.56*	0	*0.00*	0	*0.00*	13	*0.90*
1985	18	*1.48*	4	*2.23*	2	*5.90*	0	*0.00*	24	*1.66*
1986	63	*5.17*	4	*2.23*	3	*8.85*	0	*0.00*	70	*4.83*
1987	130	*10.67*	21	*11.71*	4	*11.80*	0	*0.00*	155	*10.69*
1988	233	*19.12*	54	*30.12*	8	*23.61*	2	*11.40*	297	*20.49*
1989	246	*20.19*	57	*31.80*	12	*35.41*	2	*11.40*	317	*21.87*
**Population	1,218,679		179,261		33,884		17,550		1,449,374	
1990	245	*18.65*	99	*49.86*	10	*22.41*	5	*19.26*	359	*22.68*
1991	271	*20.63*	91	*45.83*	15	*33.62*	4	*15.41*	381	*24.07*
1992	267	*20.32*	97	*48.85*	16	*35.86*	3	*11.55*	383	*24.20*
1993	632	*48.11*	212	*106.76*	37	*82.94*	12	*46.22*	893	*56.42*
1994	297	*22.61*	122	*61.44*	20	*44.83*	3	*11.55*	442	*27.92*
1995	308	*23.44*	154	*77.56*	18	*40.35*	8	*30.81*	488	*30.83*
1996	243	*18.50*	146	*73.53*	18	*40.35*	9	*34.66*	416	*26.28*
1997	192	*14.61*	106	*53.38*	23	*51.55*	3	*11.55*	324	*20.47*
1998	152	*11.57*	135	*67.99*	17	*38.11*	4	*15.41*	308	*19.46*
*Population	1,313,732		198,567		44,613		25,963		1,582,875	

*Population as of 1990 Census
**Population as of 1980 Census
Case Rates per 100,000 Population

Attachment 5

Table 10. AIDS cases and annual rates per 100,000 population, by race/ethnicity, age group and sex, reported in 1997, United States

	Adults/adolescents						Children <13 years		Total	
	Males		Females		Total					
Race/ethnicity	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
White, not Hispanic	17,649	22.5	2,485	3.0	20,134	12.4	63	0.2	20,197	10.4
Black, not Hispanic	18,903	163.4	7,880	58.8	26,783	107.2	292	4.0	27,075	83.7
Hispanic	9,776	76.5	2,578	21.5	12,356	50.6	110	1.3	12,466	37.7
Asian/Pacific Islander	331	10.2	64	1.5	445	5.6	3	0.1	448	4.5
American Indian/Alaska Native	169	23.0	36	4.7	204	13.6	2	0.4	206	10.4
Total[1]	47,056	44.0	13,105	11.5	60,161	27.3	473	0.9	60,634	22.3

[1]Totals include 242 persons whose race/ethnicity is unknown.

Table 11. AIDS cases by year of diagnosis and definition category, diagnosed through December 1997, United States

	Period of diagnosis											
	Before 1994		1994		1995		1996		1997		Cumulative total	
Definition category	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Pre-1987 definition	251,159	(60)	43,542	(33)	18,511	(28)	13,002	(24)	6,358	(20)	312,572	(49)
1987 definition	96,600	(23)	12,550	(18)	10,228	(15)	7,543	(14)	3,752	(12)	130,673	(20)
1993 definition[1]	70,076	(17)	35,117	(49)	37,494	(57)	34,111	(62)	21,043	(68)	197,841	(31)
Pulmonary tuberculosis	*5,725*		*1,607*		*1,282*		*955*		*456*		*10,025*	
Recurrent pneumonia	*2,301*		*980*		*912*		*668*		*345*		*5,206*	
Invasive cervical cancer	*307*		*141*		*89*		*56*		*26*		*619*	
Severe HIV-related immunosuppression[2]	*61,880*		*32,441*		*35,239*		*32,454*		*20,224*		*182,238*	
Total	417,835	(100)	71,209	(100)	66,233	(100)	54,656	(100)	31,153	(100)	641,086	(100)

[1]The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.
[2]Defined as CD4+ T-lymphocyte count of less than 200 cells/μL or a CD4+ percentage less than 14 in persons with laboratory confirmation of HIV infection.